

**COLUMBIA UNIVERSITY DEPARTMENT OF PSYCHIATRY
MULTI SPECIALTY CLINIC – DEMOGRAPHIC FORM**

Date: _____

1. Patient's Information

Last Name: _____ M.I. _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (H) _____ (W) _____

(C) _____

Email: _____ Type: Employee/ Student/ Employee Family

Sex: Female Male Patient's Age: _____ DOB: _____

Patient's SS #: _____

Employer Name: _____ Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Primary Doctor: _____ Referred By: _____

2. Insurance Section

Primary Insurance: _____ Coverage Type: FAM OR INDIV

Policy #: _____ Group #: _____

Second Insurance: _____ Coverage Type: FAM OR INDIV

Policy #: _____ Group #: _____

Are you the insurance policy holder? YES OR NO (If NO, please fill out section below)

3. Policy Holder's information

First Name: _____ Last Name: _____

Address: _____ City _____ State: _____ Zip: _____

Sex: Female Male Patient's Age: _____ DOB: _____

Social Security #: _____

Employer Name: _____ Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____